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ABSTRACT

This paper provides counselors and social service case workers serving Indochinese refugees in northern California with guidelines for identifying, treating and making referrals of clients with emotional problems. Freud's theory of trauma neurosis and its effect on refugees' language acquisition, learning ability and job readiness are described. Symptoms of psychological stress endemic to migrant populations are outlined: special attention is given to the identification of emotional disturbance in children and the recognition of clues indicating suicidal intent in all age groups. Literature on therapeutic approaches used in treating immigrant populations is reviewed, but the reader is advised that in developing a treatment approach for the Indochinese, unique aspects of their personality and culture must be considered. Difficulties involved in treating the culturally different are addresed, and techniques are suggested to minimize these problems. A bibliography is attached. (Author/APM)

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THE TRAUMA SYNDROME:
IDENTIFICATION, TREATMENT, AND REFERRAL
OF COMMONLY SEEN PROBLEMS

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Paper presented at Northern
California Indochinese Refugee
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The purpose of this paper is to provide Self-Support Project counselors, social service caseworkers, and Volag personnel serving Indochinese refugees in northern California with concrete guidelines for identifying, treating, and making appropriate referrals of clients with emotional problems. In addition, I was asked to give a brief description of Freud's theory of trauma neurosis and how it may affect the refugees with specific reference to language acquisition, learning and job readiness. Because of the complexity of the issues surrounding refugee resettlement, a detailed examination of these topics is not possible here. I will attempt to address the major themes in the material in order to give those of you working with the Indochinese a foundation upon which to build.

I

Before explaining Freud's theory of trauma neurosis, it may be helpful to establish a broader framework of systems of psychology in the West. By looking at the context within which psychoanalysis exists, we gain a clearer perspective of what may or may not be applicable to the Indochinese population. Marx and Hillix (1973) describe six major systems of psychology: Structuralism, Functionalism, Associationism, Behaviorism, Gestalt Theory, and Psychoanalysis. Some of these systems trace their philosophical antecedents back to western origins. Associationism is more a principle of epistemological questioning than a psychology and derives from Aristotelian logic.

Both Functionalism and Behaviorism find early influences in Darwinian evolutionary theory, as does Psychoanalysis. Freud was reinforced in his determinism and his biological view of man by Darwin's theory. These systems have distinctly western origins.

Psychoanalysis is the most widely publicized psychological system among these six, even though classical analysis has in recent years been the subject of much criticism. Within the psychoanalytic system, several schools developed as Freud's initial formulations were modified and expanded by students and followers, such as Adler, Jung, Rank and Ferenczi. Actually, Freud himself continued to develop and alter his original formulations throughout his life, and one concept that he revised was that of the traumatic basis of hysterical symptoms. Originally, Freud believed that hysterical symptoms occurred in people who suffered from "reminiscences," that is, the memory of an early traumatic event which continued to irritate the mind (Jones, 1953). He later concluded that these memories (often of childhood seduction) were not always real, but frequently were fantasied, and therefore that symptom response to trauma might not involve real external events, but could be based on the internal dynamics of the person. Initially, too, he accepted Breuer's thesis that the painful effect connected to the trauma was contained by (1) social situations which make expression of emotion impossible, or that the individual may have volitionally "repressed" it; and (2) the fact that the trauma may have occurred in a "hypnoid" state (Jones, 1953). Freud came to regret his acceptance of the latter idea, and he later replaced it with his doctrine of

"defense" (repression). He also came to believe that the traumatic event could produce any symptomatic picture, not only hysteria, and might be manifested by recurrent dreams, nightmares, hallucinations, emotional attacks, and obsessive ideas, in addition to repetitive physiological responses, such as sweating, tremor, palpitations (Horowitz, 1976).

Horowitz (1976) lucidly describes the current status of this still-evolving diagnostic classification for which there is no term in the present DSM-II ("Transient Situational Disturbance" is the most proximate of the available diagnoses). He writes:

> Basically, the issue comes down to this: if general stress response tendencies are prime factors in causing the signs and symptoms of a chronic syndrome, then stress response syndrome is a valid nosological entity. If personality predispositions are invariably prime factors in chronic responses, then "neuroses (or other diagnostic entities) following stress" is a sufficient categorization. (p. 30)

It is interesting that this controversy extends into the research literature of clinical studies on migration and refugees. Eitinger (1960) and Morrison (1973) state unequivocally that there are predispositions or traits in people that produce specific symptoms secondary to the stress of migration; Zwingmann and Pfister-Ammende (1973) are less definitive when they suggest an association between migration and mental hospitalization that cannot be explained in terms of peculiarities in the structure of the immigrant population; and Pedersen (1949) writes:

> I believe, therefore, that it is no mere coincidence that in the treatment of refugees one is almost everywhere dealing with paranoid reactions, which apparently indicates that severe social trauma--in and of itself--has a tendency to release paranoid reactions, regardless of the character structure involved. (p. 345) (All underlining added.)

In summary, it is evident that there is no clear agreement on the present status of Freud's formulation of "trauma neurosis." In view of the various opinions and supporting data, it seems highly likely that it is not an either/or situation with regard to "general response tendencies" vs. "personality predispositions", and that the choice must depend on the unique circumstances of each case. Certainly, an individual's premorbid personality is an important variable in making a diagnosis and choosing a treatment modality, and it is left up to the clinician to determine if the "prime factors" are situational tendencies or characterological. Rather than attempt to resolve this etiological question of longstanding, it seems indicated to review existing clinical data on migration and mental illness to determine if there are recurrent symptom clusters that appear in diverse migrant populations. If this is the case, it lends support to the theory that there are situational response tendencies.

II

Uprooting is a phenomenon that is affecting greater and greater numbers of the world's population. Zwingmann and Pfister-Ammende (1973) write:

> During the first half of the 20th century more than 100 million people of the Northern hemisphere left their homeland or were forcefully separated from it; they migrated, they were displaced or deported, they fled from persecution. (p. 1)

It has become clear that the negative effects of uprooting on mental health are not the exclusive domain of mental health professionals, but are also of concern to sociologists, medical doctors, economists, administrators, etc. The problems, then, require a multi-disciplinary, cross-cultural approach. This paper confines itself to examining the variety of psychopathological responses observed among previous groups of migrants, initially focusing on frequently occurring diagnoses.

Paranoid schizophrenia and paranoid psychotic reactions with persecutory trends were common diagnoses for a variety of immigrant groups. Dragonov, Rajic, Rajic, and Moravek (1971) reported paranoid psychoses among 26 immigrants temporarily employed in foreign countries. DeMartis, Taddia, and Scioli (1974) observed the development of paranoid trends among 12 male immigrant workers to Italy who were studied in depth. Eitinger (1960) found that among 60 immigrants to Norway who were diagnosed psychotic, 52 have paranoid symptoms with a distribution by sex of 44 males and 8 females. Krystal and Petty (1963) found frequent paranoid reactions among immigrants to the United States with the common delusion that American food was poisoned. Gordon (1965) found paranoid features in 54 out of 112 West Indian immigrants hospitalized in England for psychoses. Similar findings were also reported by Yeh (1972) with Chinese students studying abroad, and by

Haavio-Mannila and Stennis (1974) among new ethnic minorities in Sweden. The symptoms observed in these groups ranged from heightened suspiciousness to overt delusions and hallucinations of being followed with marked ideas of reference (i.e., being talked about, mind being read).

Unipolar affective disorder--depressive reactive type (reactive depression) was another frequent diagnosis. Pedersen (1949) reports depressive symptoms, suicide attempts, and increased withdrawal as reactions to extreme social displacements. Berner (1965) noted depressive-apathetic states among camp refugees. Eitinger (1960) cited depression, restlessness, affective outbursts with fainting and crying as symptomatic manifestations, in addition to a high degree of somatic complaints to the extent that the somatic factor influenced the diagnosis. (With patients for whom somatic complaints predominated the symptom picture, a diagnosis of a psychoneurotic-type hysteria, hypochondriasis was selected.) Krystal and Petty (1965) observed uncontrollable crying and confusional states in their patient sample. Gordon (1965) found somatic complaints in 30% of the West Indian immigrants he studied, as well as suicidal thoughts (1.8%) and confusional states (3.6%). Koranyi, Kerenyi, and Sarwer-Foner (1963) noted pity, despair, grief, and mourning at their losses with resulting aggressiveness in a group of Hungarian refugees in Canada.

There was also a preponderance of psychosomatic complaints, some of which were included as contibuting symptoms in the diagnosis of

depression. Other studies listed this separately or as hypochondriasis or hysterical reactions (DeMartis, Taddia, Scioli, 1974). Haavio-Mannila and Stennis (1974) had similar findings of hypochondriasis and hysteria with a great many somatic complaints.

Rosen (1975) makes a case for using a "forgotten" diagnostic category--nostalgia. Krystal and Petty (1963) note that prior to World War I, nostalgia was recognized by many clinicians as a separate clinical syndrome that could precipitate a psychosis. Fenichel (1954) discussed the tendency in every human being to experience a nostalgia for a state of dependence as in the first two years of life during which "omnipotent" persons care for, protect, and provide gratification for the infant. He points out that this regressive longing is often found in "oral types" who are disposed to depressions, addictions, and impulse neuroses. Zwingmann (1973) says that the nostalgic reaction has not received adequate attention because of the reluctance of persons to admit the nostalgic involvement. This presents a diagnostic problem, because many of the symptoms accompanying nostalgic reactions correspond to symptoms of other diagnoses:

> 1. Decreased working efficiency.
> 2. Fear that something could happen to members of the family.
> 3. Lowered capacity for empathy.
> 4. Guilt feelings.
> 5. Fatigue and loss of vitality.
> 6. Increased suggestibility, sensitivity and irritability, often mixed with paranoid tendencies.
> 7. Inability to concentrate.
> 8. Increased sickness and accident proneness (an especially important factor in industry).
> 9. Decreased frustration tolerance.
> 10. Feelings of hostility .
>
> (Zwingmann and Pfister-Ammende, 1973, pp. 147-148).

Because of the overlap of symptoms as shown in the above list, it is difficult to make a differential diagnosis between nostalgic reaction, unipolar affective disorder--depressive reactive type, hypochondriacal reaction, and conversion reaction; and much would depend on the particular emphasis given specific symptoms by the clinician. Gordon (1965) quite accurately points out that the Kraepelinian diagnostic system may be inappropriate to cross-cultural studies. This calls into doubt some of the diagnostic categories used in the studies already cited.

Psychoanalytic theory of trauma indirectly provides a means of classifying the symptoms manifested by migrant populations. Fenichel (1954) notes two consistent post-trauma attempts at recovery among patients. He labels these the "quieting down method" and the "stormy" method. The first aims at achieving distance from the event by withdrawing, whereas the second involves repetition of the event through dreams and imagery with concomitant restlessness and emotional spells. Horowitz (1973, 1976) describes these as states of "overcontrol" and "undercontrol" or the "denial-numbness phase" and the "intrusive-repetitive phase." These phases are not exclusive, but often alternate with periods of denial being followed by periods of increased ideation and emotion. Horowitz (1976) summarizes the typical phasic pattern of stress response as an initial outcry (a reflexive emotional expression, such as "Oh, no, it can't be true!"), followed by denial, then intrusion, then working through, and finally completion (mastery).

By way of example, delusions and hallucinations in paranoid psychoses may be viewed as follows: Rather than accept the reality of a loss of social, financial, and professional status, the immigrant loses the appropriate perception of reality and projects the problems onto a hostile environment in an attempt at denial. This effort may also manifest as psychosomatic symptoms, as in conversion reactions, or as emotional numbness--both of which are further efforts to deny reality. On the other hand, symptoms found in unipolar depressive states, such as sleep disturbances, difficulty concentrating, confusional states, emotional attacks, and somatic problems such as colitis, asthma, migraine, and hypertension would be grouped in the intrusive-repetitive phase. The use of this system of phasic classification has implications for treatment. Rather than attempt further paraphrasing of a new and complex theory, for a more detailed understanding refer to Horowitz, M.J., Stress Response Syndromes, Jason Aronson, 1976.

The preceding clinical observations of immigrants, as well as Horowitz's research, were carried out primarily with adult populations. How might the stress of immigration affect Indochinese children? Nissen (1973) notes that symptoms (depressive) manifest themselves differently in children and adolescents, approaching adult symptomatology in late adolescence. Several studies indicate that school behavior problems and acting out are seen frequently in second and third generation children in response to stress (Raman, 1960; Triseliotis, 1965; Nicol, 1974).

The importance of parental attitudes, conscious and unconscious antagonisms, towards the new culture are often transmitted to the children who are faced with conflicting loyalties between home and school (Triseliotis, 1965). Delabre (1974) finds identity problems in children confronted with a second system of values as their exposure and need to adapt to new social norms increase. Similar findings are given by Ho (1976) who notes that second and third generation Asian-Americans experience guilt and shame because of difficulty in resolving a culture conflict that makes living by traditional values taught at home maladaptive in the larger social system. Onoda (1977) found higher neurotic tendencies among a sample of 144 Sansei* 10th - 12th grade highschool students than a comparable group of Caucasian students. He adds that the Sanseis are likely to manifest a major portion of their stress through physical ailments.

To illustrate some of the problems related to identification of emotional disturbance among the Indochinese children, I quote from the school reports of a 9-year-old Vietnamese girl that I recently evaluated:

> First Report, 1/29/76: A is very shy and will not talk to us, although when she is alone with someone she will talk. She is beginning to read with her group.
>
> Second Report, 3/29/76: The children in my class are very fond and protective of A. A has begun to whisper to us in class. She is trying very hard. She is still shy. She can read the

* Sansei = third generation.

words in her book, but I'm not sure if she understands the story.

During the year, the family moved from San Francisco to Oakland, because A's behavior at home was increasingly bizarre and creating problems with the neighbors. Mother reported that A had been beaten up several times by other children at the school and was afraid of going. The next series of reports from Oakland are for 1977:

> Second Report (from Oakland): A has been with us for such a little time and has had to make many and great adjustments. Therefore, she will not be assigned any grades at this time. We are very happy to have her with us and do look forward to her making more progress.
>
> Third Report: A is still making adjustments to her new class. She works very hard with Spelling, Math and Writing and does very well. She still likes to work with one person and is quite shy. Still, we are proud of her progress. Thank you for cooperating.
>
> Fourth Report: We are so sorry A took sick and was unable to be with us this report period. We do hope by September she will be well and with us again. She will be going into third grade for the Fall. Thanks again.

In a report I received from a social worker who had seen A in play therapy for six months subsequent to her leaving school, several prolonged tantrums were described, apparently directed at Mother, in which A screamed, threw things and spit. A child psychiatrist was consulted, and he prescribed Vistaril 25 mg. daily. During the six months of play therapy, A was an elective mute while at the clinic, communicating only by writing notes to the social

worker. When I first saw A, together with her mother and a Vietnamese social worker, the child refused to separate from her mother's side, appeared freightened, was laughing to herself which alternated with periods of silence, and then periods of screaming and crying. Mother described her behavior at home as follows: A laughs and talks to herself; cries out at different times; sometimes doesn't seem to recognize siblings; has nightmares; refuses to get out of bed; is retaining her feces.

I saw A, her mother, and the social worker in my office the following week and noted little change in behavior. During the week, I had contacted the family pediatrician who had begun to prescribe a Phenothiazine (Millaril) and Colace. I also began looking into Day Treatment or Residential Care facilities in the Bay Area. The mother is very reluctant to consider this alternative at present.

My last contact with A was made in a visit to her home with a Vietnamese counselor from the local Indochinese Mental Health Project who has assumed responsibility for the case. A's behavior had improved slightly: She was less affectively labile, eating and sleeping with more regularity, and moving her bowels more frequently. However, I observed her laughing and talking to herself twice, and she continued to refuse to communicate verbally with us.

During this visit, we learned of an older sister B, aged 14, who spends almost all of her time in her room during homework and refuses to interact with other family members. This has been going on for over a year. The three other siblings were seen briefly

and appear to be doing well, but this judgement is based on very superficial observations. Mother did report that the six-year-old boy (the only son) is acting more demanding of her time.

The father returned home at the end of the interview. He works as an accountant in a San Francisco bank, but views this as a loss of status from his job as a highschool physics teacher in a Vietnamese highschool. The Vietnamese hold teachers in very high regard. He had been attending night school, but now was not going. He mentioned several times that he and his children were so busy between work and school that there was little time to be together during the day. He said that he wanted to be more involved in helping A.

I am still pursuing the possibility of a residential home for A. None of the Day Treatment programs in the East Bay are prepared to accept her. Meanwhile, the counselor from the I.M.H.P. is making weekly home visits and coordinating medication with the family pediatrician. Several other steps have been made towards helping the mother disengage from her involvement with A and enlisting other family members as caretakers.

This story was presented in such detail to illustrate several points: First, I believe that we are only beginning to see the proverbial tip of the iceberg with regard to mental health problems among the Indochinese, not only for children, but adults, as well. Families will be very reluctant to utilize existing community agencies, as has traditionally been the case with minority ethnic groups,

especially Asians (Sue and McKinney, 1975). Secondly, there is an obvious need for training teachers and others, like yourselves, who are in frequent contact with Indochinese to be aware of signs and symptoms of emotional distress. The immigrants themselves may not even be aware of the problems. For example, one complaint often heard is, "I ache all over." Thirdly, staff of Indochinese projects should be used not only as providers of direct services, but also as consultants to schools, hospitals and other agencies working with the Indochinese.

Chu (1972) identified a high-risk subgroup (i.e., to emotional disorders) among Chinese migrants as persons who (1) live alone, (2) are single or separated from their spouse, (3) are male and over 30, (4) are experiencing lower socio-economic status than before. This correlates very closely with the sociological factors associated with suicide in the United States, some of which are (1) middle to older age, (2) male (70%), (3) unemployed, (4) transitional and slum urban area renters, (5) West Coast, and (6) poor and/or chronic depression with alcohol use (Rosenbaum and Beebe, 1975). I found no statistics or demographic data on suicide relating specifically to the Indochinese.

Briefly, what are some clues that may indicate suicidal intent? In addition to a direct statement or threat of suicide, there are indirect clues that counselors can look for: (1) Affective states of hopelessness and/or helplessness, euphoria, and psychomotor retardation (i.e., long reaction time to questions and a generally

slowed, immobile appearance); (2) Fantasy clues (i.e., imagining death as revenge against others); (3) Self-deprecating remarks (i.e., "I'm no good.", "I'm worthless."); (4) Behavioral clues (i.e., a 13-year-old Vietnamese boy at Camp Pendleton made a tombstone and placed it on the foot of his bed. Refer to Harding and Looney, 1977).

However, it is important to remember that there is no single trait by which suicidal people can be identified. For the non-professional who is working with someone who may be suicidal, a supportive attitude aiming to renew feelings of hope, love and trust can provide emergency scaffolding for the client. But psychotherapy with suicidal patients is a specialists' art, and referral of the client to an appropriate agency or seeking professional consultation is likely to be indicated.

III

There have been a variety of therapeutic approaches used in treating emotional problems of other immigrant populations. An examination of some of these efforts may suggest possible treatment modalities for use with Indochinese. Dunkas and Nikelly (1975) found that group therapy with Greek immigrants offered a unique solution for psychological problems caused by cultural stress and conflict. Kim (1976) recommends that Korean ministers be trained as a link between the Korean immigrant populace and the larger social welfare community, because there is less shame and guilt involved in going to

one's minister with problems. It is a more traditional, acceptable pattern of behavior. Koranyi, Kerenyi, and Sarwer-Foner (1963) treated Hungarian refugees in Canada after the 1956 revolution. In their study, 69.8% of the post-revolution sample were in treatment for less than three months. Reasons offered were (1) as immigrants, people had lower socio-economic status and could not afford longer therapy, (2) Hungarians responded to a more directive, doctor-patient treatment orientation, and (3) the immigrants had not had time to adopt a more "Canadian" concept of psychiatric treatment. The type of treatment was primarily supportive psychotherapy or supportive psychotherapy plus psychotropic medication. The authors see psychiatric care in all cases as essential in helping individuals adapt to the new and stressful situation which was exacerbated by the abruptness of the change. Triseliotis (1965) found that few immigrants made use of psychiatric clinics and that there was a need to actively demonstrate the utility of the experience. He found that he was more active and directive in working with immigrant families. Wynne (1969) insists that in situations involving social displacement the entire family should be the focus of intervention. Tung (1972), in one of the few papers describing the management of mental health problems in Viet Nam, says that given the especially close-knit organization of the patriarchal family, very often the family is not an accessory to treatment, but the crux of the matter.

Other authors suggest some approaches for use with Asian-Americans who are not recent immigrants to the United States. Sue (1977)

stresses the importance of control or perceived control of one's environment as essential to promoting "mental health." He offers the opinion that assertive training may be valuable for the Asian-American who has a traditional view of life events as being beyond his/her control. Wake (unpublished paper) notes that Japanese-American families are reluctant to seek professional help until situations have reached crisis proportions, that self-disclosure is not within the experience of these people, that they are skeptical of the value of therapy, and that they will come into therapy feeling ashamed that they haven't been able to work out their own problems. She advocates home visits in preference to having the family visit the agency, initial use of an authoritarian/directive approach in preference to approaches that require more subjective self-disclosure and self-analysis, and an increase in the number of bilingual Japanese-American therapists. Ho (1976) points out that a majority of Asian-American interpersonal problems center on cultural marginality and that a therapy that focuses on exploration of self-identity and fulfillment of self-esteem may only increase the client's guilt feelings becuase of the difficulty the client has in living by older, more traditional cultural values. This would be more true for second and third generation immigrants. She encourages use of a directive approach (particularly in the initial stages of treatment) with emphasis on concrete service needs. She also makes reference to the likelihood of guilt feelings among family members for having failed to resolve problems within the family group. She suggests the

use of a home visitation team as a mean of reducing this guilt. Dunkas and Nikelly (1975) found a characteristic modal personality emerged from their sample of patients that was typical of Greek culture and that required specific techniques of treatment consistent with that culture. The same situation is likely to apply to the Indochinese, and in developing a treatment approach, the unique aspects of Indochinese personality and culture must be considered.

IV

Rather than attempting to explore the psychodynamics of Laotian and Cambodian personality, this section focuses on the Vietnamese. Much of the material is taken from several papers by Dr. Walter Slote who conducted extensive in-depth interviews of Vietnamese in Viet Nam in the mid to late 1960's.

Slote (1972) says that in the unconscious self-image of the Vietnamese, he views himself as a component within a broader, collective ego structure. The western concept of an individualized, self-determining ego structure is less clearly established, and in the absence of a uniquely defined ego, role playing is a common compensatory mechanism. This role adoption is because of societal and cultural values derived from Confucianism with its emphasis on stylized roles, correct conduct, and parent-ancestor worship. Within this context, feelings and emotions are institutionalized so that emotional content is dissociated and affective reaction patterns are

forced into a universally acceptable mold. Chang (1965) notes that the effect of Confucian emphasis on proper human relationships, as observed in Japan, is a tendency to internalize interpersonal conflicts, accounting for a prevalence of hypochondriacal symptoms and a lower incidence of acting out behavior. Marr (in press) argues that the influence of Communist ethical values in Viet Nam has not been given adequate recognition and that the Neo-Confucian view of the Vietnamese as passive recipients of morality is over-simplified and incorrect. Slote (1972) asserts, however, that passivity and acceptance are positive characteristics of the Vietnamese personality, serving as adaptive strengths during periods of colonialization or turmoil.

These two authors present contrasting views of the Vietnamese personalities. Slote adheres to a classical, Neo-Confucian, traditionalist position. He points to the family as the basic unit of the society and asserts that this plays a critical part in maintaining the individual's mode of relating in the world. This dynamism is achieved in actuality or, if a person is separated from his family, eiditically because a person knows precisely what position his family and community would take on any issue. Marr (in press) contends that the centrality of the family in Vietnamese society has long been the subject of Marxist-Leninist criticism, so that the extended family is of far less significance than before, although the nuclear family remains a key social element. In a recent paper, Slote (1977) argues that the Vietnamese live iwth the profound conviction that life is determined by forces over which they have minimal control.

The responsibility for "bad events" is externalized (i.e., astrological explanations, numerology, phuc duc--an accumulation of rewards for moral excellence in this life that affects the lives of succeeding generations into the fifth generation) and is therefore integrated into one's psychic apparatus with a minimum of emotional dislocation. Therefore, he believes that the present adult generation of immigrants will not experience a great deal of psychological upset as a result of their new life circumstances. Marr (in press) concludes that the tradition-breaking aspirations of the Vietnamese Marxist-Leninists have been partially realized since 1941, and the Communist victory in 1975 reflects to an extent this change.

Neither Slote nor Marr examine what effect the more than twenty years of war and forced displacements and "relocations" have had upon the family and Vietnamese personality. Slote's interviews were carried out primarily before 1968, at which time the intensity of the fighting and the American involvement increased. Wynne (1969) notes that exogenous change due to war or displacement accelerates the process of family disorganization and deterioration. When one studies the demographic characteristics of the Vietnamese immigrants, the following statistics stand out: (1) 45.9% were younger than 18 and 35.6% were between 18 and 34; (2) 86.5% were part of a household or family group; (3) more than 40% are Catholic; (4) they are exceptionally well educated by Vietnamese standards--37.9% had secondary schooling and 16.6% some college; and (5) occupationally, people with professional, managerial and technical skills make up close to one-third of the group,

and an additional 19.4% have skills that relate to modern industrial economies (Kelly, in press). From these figures, it appears that the majority of immigrants are young, from the technological sector of the economy, and well-educated. One likely conclusion is that this group is more westernized or at least have been more exposed to western ideas and values, which may mean that traditional Neo-Confucian concepts have less significance for them than Slote infers. David (1969) notes a similarity between the needs of any recent immigrant and a newly born infant (i.e., needs for belonging, love, understanding). He sees patterns of regression in immigrants from which it could be inferred that even this westernized group of refugees might revert to more traditional beliefs. This question remains open to debate, but it does have implications for selecting therapeutic interventions. A treatment modality should be flexible enough to provide for inclusion of both views of personality.

V

Cultural factors obviously must be a critical variable in the process of designing a therapeutic intervention for use with the Indochinese. Our systems of psychological theory from which psychopathological diagnoses and subsequent treatment goals have been derived find their roots in western philosophy. Lindemann (1969) suggests that the goals of psychotherapy and even the definition of psychopathology should differ between East and West, because eastern themes

of dependency in interpersonal relations and the value of a supportive network in kinship and community contrast with western emphasis on separation/individuation and the development of an individual identity. He points out that diagnosis under circumstances of rapid social change refers not so much to a disease picture as to categories of disturbed behavior in relating to the time and sequence of psychological events after such crises. The particulars of the adaptive crisis at hand should be carefully studied (i.e., equipment and psychological resources of the individual and his group to deal with the crisis and the demands of the new environment).

Horowitz (1976) has developed a treatment approach for handling stress responses to recent traumatic events that considers the temporal (phasic) nature of symptom development and that may be flexible enough to allow for the inclusion of cultural variables in decisions about appropriate treatment goals. He concludes that there are two basic treatment aims among the variety of modalities: (1) Aims at reliving, analyzing, and working through the stress event, and (2) aims at supporting and moving away from the stress event. A decision must be made involving the direction that therapy will take either towards character or "core neurotic conflict" analysis or towards working through the stress event to completion. These are the extremes of the two therapeutic goals, and there are many intervening decision points (i.e., partial character analysis). The techniques involved in the briefer treatment goal of working through may vary, but the technique involved with character analysis is less amenable

to alteration. Horowitz (1976) locates the initial decision point about therapeutic goals during intensive-repetitive phase when the patient is bringing up material and reactions; a second decision point occurs if one has initially chosen to work through the stress event and may then want to undertake character analysis. Again, the reader is referred to Stress Response Syndromes for a more detailed exposition of this theory (particularly pp. 122 - 130).

The decision points in this process offer the opportunity for inclusion of cultural variables. In choosing to work with the stress event rather than doing a character analysis, Horowitz considers several points which could include cultural factors: (1) "The general maladaption of the patient." A clinician must decide if ethnic minority membership is a dominant factor in the maladaptive state or if the difficulties are more characterologic. This is not an either/or variable because of the facticity of racism in the United States. (2) "Readiness and capacity of the patient to change." This factor affects the decision about general maladaption of the patient. What is the language ability of the patient? What is the capacity for insight? Are the cultural goals and values of the patient consistent with an analytic, character/conflict type of therapy? What class values does the patient bring to treatment and are these compatible with the goals of therapy? Previous research indicates many basic philosophical differences existing between East and West that seem to argue for the avoidance of in-depth, analytic therapy. This is most probably the case with members of this first

generation of immigrants. But among second and third generations, there may be greater "readiness" and "capacity" to undertake character analysis because of identity questions due to biculturalism (Sommer, 1964).

Sue (1977) offers another model specifically designed for counseling the culturally different. Essentially, it is constructed to emphasize the importance of cultural variables in working with people from ethnic minorities, and it stresses the appropriate matching of therapeutic processes to therapeutic goals after carefully weighing the patient's cultural background. Tseng and McDermott (1975) also recognize that the patient's orientation to the healing system is a crucial factor in therapeutic outcome, and they assert that the dynamic explanation of the problem ought to be familiar and culturally meaningful to the patient. For example, psychodynamic explanations involving id, ego and superego are likely to be of little use to an Indochinese refugee. Fenichel (1954) refers to a paper by Glover which investigated the influence of incomplete or inexact interpretations, as well as other psychotherapeutic maneuvers, on the patient. Glover's answer was that these procedures offer artificial substitute symptoms (See Fenichel, pp. 248 - 249). Fenichel insists that therapeutic efforts of this type succeed when the substitute offered is (1) suitable to the dynamic structure of the patient (i.e., a hysteric cannot accept "artificial compulsions"), (2) pleasurable, and (3) not overly obvious a replacement. In addition to psychodynamic relevance, it seems apparent that cultural factors must be

considered when formulating a therapeutic intervation. These suggestions for cultural relevancy of treatment intimate that therapy for many Indochinese should be supportive and should attempt to bolster already-existing cultural defenses--at least among this first generation of immigrants.

Although A is not an adult, an examination of her case may help clarify some concepts discussed in the preceeding paragraphs. A's history suggests that she has been vacillating between denial-numbness and intrusive-repetition, depending to a great extent on her environment. At school or outside the home, A has been for the most part selectively attending to stimuli by withdrawing and remaining mute--constricting her world. From reports, this was not fully successful, and Mother and family became involved in assisting A by moving their home and by Mother's leaving her job to devote full time to A. At home, A has been experiencing intrusive illusions, sleep and dream disturbances, nightmares, and emotional attacks. When I saw A, intrusive symptoms were predominant (i.e., illusions, emotional attacks), even though she was not speaking. The initial decision to use medication is aimed at suppressing A's emotional swings and providing more rest.

The next level of intervention was with the mother. She had reported that to calm A's disturbed sleep, she had been sharing the same bed with A for the past seven months. During the war in Viet Nam, it was not unusual for entire families of four to six people to share the same bed. However, Mother said that, although the children shared their beds, she and her husband had slept together up until

seven months ago. I adopted a directive approach with Mother, telling her to move into a bed that was next to A's, and insisting that she herself leave the house for one hour a day, during which time A was to remain with an older sibling. Mother expressed some relief upon hearing this. Arrangements for a second interview and a home visit were made.

In the following week, a Vietnamese counselor from the I.M.H.P. agreed to follow this case. Because of A's fear of westerners, this seemed a good way to further reduce her anxiety. This counselor contacted A's pediatrician and coordinated the delivery of medication to the home, so that Mother would be able to have the dosage schedule translated into Vietnamese. The second interview served to gather additional information, to learn if Mother had followed directives, and to arrange for the home visit during which the I.M.H.P. counselor would meet the family. Mother reported that A would wake during the night and get into the nearby bed in which Mother was sleeping. Mother was beginning to get out of the house. Nothing else had changed.

During the home visit, it was possible to talk with all the family members except A and the withdrawn elder sister, B. It became evident that the family unit was in disarray. In a sense, the family was experiencing its own intrusive-repetitive phase (i.e. confusion and disorganization, emotional attacks). The children were involved with school and ate whenever they were hungry. Father seemed tired and responded to a question about the daily routine by saying that there was no time for the family to sit down together for a meal.

The family, when viewed as patient, required externally supplied structure, an opportunity to become involved with one another again by developing mutual dependencies, and support. By utilizing the authority of the doctor-patient model, these additional directives were offered: (1) The two elder siblings and father should share the responsibility of caring for A more and more; the children were encouraged to involve A in play activities; (2) Mother was supported in her separation from A; and (3) the family was asked to plan and have at least one meal together every day.

It is intended that by introducing more structure to this fragmented family, their traditional pattern of mutual dependency will begin to operate. If this occurs, it will also provide a more stable, predictable environment for A. In view of the problem of the other child, B, it may be that the family problems are more extensive. This evaluation will be made over time. The counselor visiting the family is functioning as a source of support, as a model for interacting with A (i.e., she is playing with A and involving the siblings), as a relief for Mother who leaves the home during the visit, and as a contact for the pediatrician to help with monitoring medication. This is the present situation. It may still be necessary to remove A from the home, but presently efforts are directed at enlisting the entire family (a dynamically and culturally acceptable substitute) in working with this case.

Reiterating three points learned from A's case: (1) It is difficult to detect emotional disturbance in the immigrants.

(2) Families are likely to go to extremes to protect a member--even to the extent that the family is over-taxed and begins to suffer.
(3) It is important to have Vietnamese (Laotian, Cambodians) involved directly or as consultants when working with the immigrants to provide insight into cultural factors.

VI

Previous studies of acculturation among immigrants have resulted in a better picture of the variables most crucial for facilitating the process of adjustment. These include the ability to learn the new language (Mostwin, dissert. abst.; LaRouche, 1973; DeMartis, 1974; Krystal and Petty, 1963; Koranyi, Kerenyi, Sarwer-Foner, 1963) and employment satisfaction (Mostwin, dissert. abst.; Goetzl, 1973; Shannon and Shannon, 1973; Weinstock, 1964). In a study of 47 Vietnamese school children aged 9 to 15, Leichty (1963) found that work is regarded as the major aspect of everyone's life. Murphy (1972) says that the best mental health and adjustment of immigrants are found when individual goals are in accord with perceived means of reaching these goals, and the individual is able to advance along a series of short steps, each with its own limited and attainable goal. The question of how anxiety or stress affects a person's capacity to learn and problem solve is central to devising programs intending to facilitate acculturation.

Gardner (1971) observed that children with learning disabilities have an extremely high overload of anxiety and that this overload arises from an excess of traumatic incidents and violent events in the first six years of life. This finding has direct implications for the present situation in which the Indochinese immigrants find themselves. Psychologists have long recognized the relationship between anxiety and learning. Yerkes and Dodson formulated a principle that has attained almost universal acceptance among behavioral scientists. This principle, referred to as the Yerkes-Dodson Law, holds that the relationship between fear, conceptualized as a drive, and learning is curvilinear (Levitt, 1967). This means that, with low levels of anxiety, learning is not facilitated and also that high levels of anxiety interfere with the learning process, sometimes to an even greater extent. Although it is difficult to quantify, optimal learning seems to take place in the middle range of anxiety or drive intensity. The law also asserts that learning is a function of task complexity, and optimal learning occurs when tasks are simpler. For optimum problem solving, simple tasks building to more complex ones will produce better results. Although the research does not examine the specific question of job readiness, this may be viewed as a problem-solving situation in which high levels of anxiety will interfere. Structure, simplication of tasks, and support should assist in preparing for learning or employment. The Taylor Manifest Anxiety Scale derived from the Minnesota Multiphasic Personality Inventory can be a means of

assessing a person's anxiety level prior to entering a training program. In cases where severe anxiety is indicated, previous intervention of a supportive type or even use of anxiety reducing medication may be facilitative.

VII

As Sue and McKinney (op. cited), Triseliotis (1965), Wake (unpublished paper), and Lindemann (1969) all make note of, there is a great difficulty with the psychiatric approach to case finding in the traditional sense when working with ethnic minorities. The populations of Asian-American and also the Indochinese immigrants seem able to tolerate and accept a number of psychotics. Guilt and shame prevent many Asians with emotional problems from utilizing traditional community mental health centers (Ho, 1976). These findings imply that creative alternative interventions may be efficient in ameliorating emotional stress in the immigrants. Sue (1977) advocates organization and maintenance of cultural heritage programs as a supportive device. Other authors emphasize the importance of culturally and ethnically compatible neighborhoods for the promotion of better mental health (Morrison, 1973; Bjornson, 1971). Lindemann (1969) writes:

> My own concern has been with the details of community arrangements to assist persons in transition, rather than with counting the cases of illness among migrants and nonmigrants. (p. 483)

Triseliotis (1965) notes that, by grouping together, immigrants provide emotional and social support for each other. This may be problematic for many Vietnamese, due to the years of war and the mistrust that war engenders. An article by Lynn Darling in the July 10, 1977 Washington Post quotes a Vietnamese refugee:

> You see there is no togetherness in the Vietnamese community at all. It's a sad fact, but we behave as if we were still at war. War changes people. They don't trust one another. We are strangers here.

David (1969) finds a general consensus in the literature that migrants who are well briefed on their new socio-cultural environment tend to adapt more readily than those who are ill-informed. The staff at the San Francisco Indochina Mental Health Project is presently developing an educational-informational program of talks and films to introduce in the schools this Fall. They hope to involve teachers, parents, as well as immigrant children, in an educational dialogue to promote better understanding of the process and problems of acculturation. This program complements the direct service function that I.M.H.P. is already providing to the Indochinese refugee community.

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